

TRICARE Fundamentals Course

Module 13

Claims & Appeals

Participant Guide

References


32 CFR §§ 199.7, 199.10

OPM Part III, Chapter 13


TRICARE Operations Manual 6010.51-M, August 2002, Chapter 8

TRICARE Reimbursement Manual, 6010.53, March 15, 2002, Chap 2, Addendum A

Module Objectives




Module Objectives




- Explain who may file claims and to whom they should be submitted
- Explain the process involved in beginning to resolve a claim issue
- Explain three reasons why a claim may be denied
- Recognize what can and cannot be appealed

Claims



Claims



- What are claims for?
- Who may file a claim?
- To whom are claims submitted?
- Who is ultimately responsible for submitting claims?

What are Claims for?

Claims are filed to request reimbursement for services or supplies provided by civilian sources of medical care which include, but not limited to:

- Physicians
- Hospitals
- Nursing facilities
- Pharmacies
- Medical suppliers
- Ambulance companies
- Laboratories
- Physical therapy
- Vendor pharmacies
- VA treatment facilities
- Other authorized providers

Who may File a Claim?

The person submitting the claim is either the provider of services or supplies, or the beneficiary:

- Any TRICARE-eligible beneficiary
 - A spouse, parent, or legal guardian of a minor or incompetent beneficiary may act on behalf of the beneficiary submitting a claim, unless otherwise specified.
- Any authorized provider approved under TRICARE for services or supplies provided to a beneficiary and receives payment directly from TRICARE
 - Institutional providers include hospitals and nursing facilities
 - Professional providers include an independent provider or group practice

To Whom are Claims Submitted?

Claims are submitted to the appropriate claims processor. There are two:

- PGBA (Palmetto Government Benefits Administrators)
- WPS (Wisconsin Physicians Service)

Note: The beneficiary submits claims to the claims processor responsible for the region where the beneficiary lives. Exception: All TRICARE For Life claims are submitted to WPS, the TRICARE Dual Eligible Fiscal Intermediary.

If beneficiaries send their claims to the regional contractor, the regional contractor will forward it to the appropriate claims processor. If a claim goes to the wrong claims processor, standards exist to forward the claim to the correct processor.

TRICARE beneficiaries have the responsibility to make sure their demographic data are current so their claims go to the correct claims processor.

All TRICARE-eligible beneficiaries have the responsibility to keep their demographic data current in the Defense Enrollment Eligibility Reporting System (DEERS).

Claims Processing Procedures

Specific TRICARE claims processing procedures apply. The purpose of following those procedures is to ensure that:

- All claims for care received by TRICARE beneficiaries are processed in a timely manner, and
- The government-furnished funds are expended only for those services or supplies authorized by law and regulation.

The claims processor must process all claims to ensure that sufficient information has been submitted to determine whether:

- The beneficiary is eligible.
- The claim has been filed within the given time limits.
- The provider of services or supplies is authorized under the TRICARE Program.
- The service or supply provided is a benefit.
- The service or supply provided is medically necessary and appropriate or is an approved TRICARE preventive care service.
- The beneficiary is legally obligated to pay for the service or supply (except in the case of free services).
- The claim contains sufficient information to determine the allowable amount for each service or supply.

Resolving Claims Issues

- The Beneficiary Counseling and Assistance Coordinators (BCAC) and the Debt Collection Assistance Officers (DCAO) are the front line customer service persons who see or hear beneficiaries with claims issues.
- The following list should be considered and questions asked of the beneficiary when conducting an initial claim inquiry for the beneficiary:
 - Did the beneficiary contact the claims processor for their region? If so, what was the result?
 - What is the issue? Determine whether the claim never processed, was denied, the beneficiary disagrees with the decision, etc.

- Did the beneficiary bring in his or her explanation of benefits (EOB), summary payment voucher, or bill, or did they happen-by because they were close to the TRICARE Service Center (TSC)?
- If the beneficiary states they never received an EOB, look up the information on the Web, if possible, then call the processing unit (PGBA or WPS) to determine if a claim was submitted by the provider. If not, call the provider to determine if and when the claim was sent to PGBA or WPS.
- What is the current status or past status, or category of the beneficiary under TRICARE as displayed in DEERS?
- What type of medical service was rendered i.e. medical appointment, Rx, supplies?
- When was the date of the service?
- Was this service rendered as an inpatient or outpatient?
- If the EOB is available, look at the admin notes at the bottom to determine why the claim paid the way it did i.e. Point of Service (POS), no authorization on file, Social Security Number (SSN) is invalid, not a TRICARE benefit etc.

Note: BCACs and DCAOs should work with or try to work with one key individual, no more than three at PGBA or WPS to build rapport and maintain consistency in the communication process when researching/resolving beneficiary's claim(s) issues.

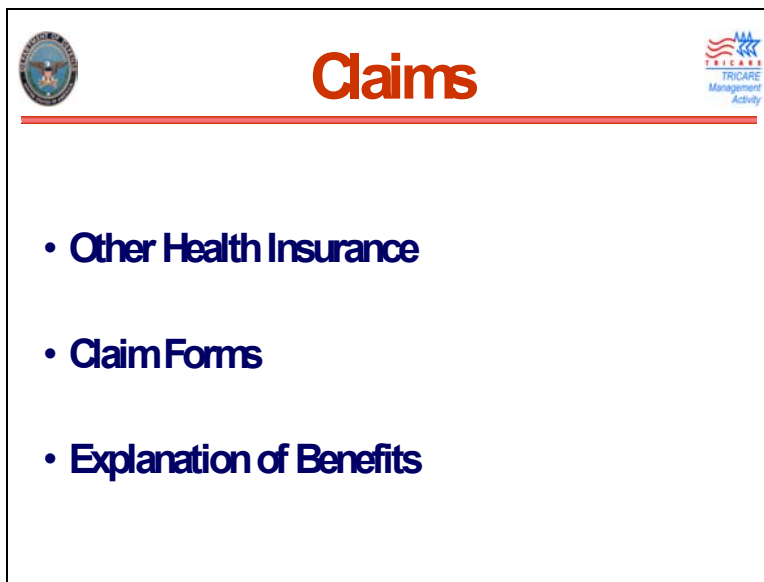
When does the Provider Submit Claims under TRICARE?

- If the beneficiary sees a non-network, non-participating provider, the beneficiary may be required to file the claim.
- If the provider of services is a network provider, they are required to file claims.
- If the provider accepts assignment from TRICARE, it will submit claims for beneficiaries.
 - Those providers who accept assignment can do it on a case-by-case basis.
 - They usually accept assignment when the fees they charge match the amount they will be reimbursed.
 - The provider may request that the beneficiary pay 100 percent of the bill up front:
 - The maximum amount of reimbursement the provider will receive is 15 percent of the TRICARE allowable charge.
 - This is an example of when a beneficiary gets involved in balance billing

Responsibility for Filing

- If the beneficiary sees a network provider, it is the provider's responsibility to make sure that claims get filed.
- If the beneficiary sees a non-network, non-participating provider, it is the beneficiary's responsibility to make sure that claims get filed.
- All claims must be filed within one (1) year of the date of service.
 - Beneficiaries should be encouraged to file as soon as possible.
 - Recommend to beneficiaries they ask their civilian providers if they will be filing the claims.

After claims are submitted, the beneficiary and provider (if the provider filed the claim) will each receive an EOB from the claims processor showing the services performed and the adjudication (or settlement of payments).



Other Health Insurance

Special circumstances exist when beneficiaries have other health insurance.

- If a beneficiary has other health insurance (OHI), the beneficiary or the provider must file a claim with that health insurance plan before filing with TRICARE.
- After the OHI has decided what it is going to pay, a claim can then be filed with TRICARE along with a copy of
 - The other health plan's payment determination
 - The itemized charges (bill)
- If beneficiaries do not tell TRICARE, the regional contractor, the claims processor, or DEERS about their OHI, the claim could be delayed in processing or even denied.

Claim Forms

Beneficiaries need to be reminded they should not combine claims. That means they should send a separate claim for a visit to a provider's office and separate claim for pharmacy or any other service or supply received. Also, they should submit a claim for each family member even though they may have visited the same provider on the same day.

Sent in by Beneficiaries or Family Members

- DD Form 2642, "CHAMPUS Claim Patient's Request For Medical Payment"
 - Submitted for services or supplies provided by civilian sources of medical care
 - If submitted by a provider, the form will be returned to the provider
 - Can be downloaded from the TRICARE Web site:
www.tricare.osd.mil/claims/Dd2642.pdf
 - Can be downloaded from the PGBA's Web site: www.mytricare.com
 - Can be downloaded from the WPS' Web site: www.tricare4u.com
 - Also available from TSC, BCAC, or Health Benefits Adviser (HBA)

Sent in by Beneficiaries or Family Members, or Provider

- DD Form 2527, "Statement of Personal Injury – Possible Third Party Liability"
 - Required to be submitted with DD Form 2642 when filing in instances in which a beneficiary's condition is accident-related, work-related, or both
 - Can be downloaded from the TRICARE Web site:
www.tricare.osd.mil/ProviderHandbook/DD2527.pdf
 - Can be downloaded from the PGBA's Web site: www.mytricare.com
 - Can be downloaded from the WPS' Web site: www.tricare4u.com
 - Also available from TSC, BCAC, or HBA

Sent in by Providers

- CMS 1500, "Health Insurance Claim Form"
 - To be used by professional providers
 - Can be downloaded from the TRICARE Web site:
www.tricare.osd.mil/claims/1500-90.pdf
 - Can be downloaded from the PGBA's Web site: www.mytricare.com
 - Can be downloaded from the WPS' Web site: www.tricare4u.com
 - Also available from TSC, BCAC, or HBA
- UB-92 (CMS 1450)
 - Used for inpatient or outpatient care from hospitals and other institutes
 - Can be downloaded from the WPS website:
www.tricare4u.com/apps/tricare2/pdfs/h1450.pdf
 - Can be downloaded from the PGBA website:
<http://www.cms.hhs.gov/providers/edi/h1450.pdf>
 - Not readily available at TSCs.

When Medical Care Received Overseas

- Beneficiary may submit a DD Form 2642.
- Foreign providers are to submit DD Form 2642 or CMS 1500.

Forms are also available from

- TSC, TRICARE Claims Processors, BCACs, or HBAs at the nearest MTF
- As a last resort, beneficiaries may also get claim forms by writing to TRICARE Management Activity, 16401 E. Centretch Parkway, Aurora, Colorado 80011-9066.

Items That May Need to be Submitted with Claims

(*Note:* Although the provider may submit the claim, the beneficiary may be requested to obtain these items):

- Non-availability Statement (NAS) Authorization Number
- Referral Number
- Itemized list of charges for each service or supply
- Must be on the provider's letterhead or standard form
- Itemized list of charges from pharmacy
- Must be on pharmacy's letterhead or billing form
- Other health insurance
- The health plan's payment determination or denial/EOB
- DD Form 2527, "Statement of Personal Injury – Possible Third-Party Liability"

How Soon After Submitting a Claim Should an EOB be Received?

- For the majority (95%) of claims that are able to be processed, the beneficiary and the provider each should receive an EOB within 6 weeks of submitting a claim.
 - Some complex claims may take 60 days to complete.
 - Check the claims processor's Web site or call to determine if a claim has been received.
- The provider should be contacted if not received to determine if the claim was submitted in a timely fashion.
- Beneficiaries should be aware that EOBs are sent to the address they put on their claims forms or the address their provider has in their files.
 - Addresses on claim forms are considered the most recent and accurate.
 - DEERS should be kept updated, too.

- Some other reasons for a delay in receiving an EOB:
 - Wrong address
 - Claims returned if incomplete
 - Eligibility is being questioned
 - Diagnosis is missing
 - Third-Party Liability
 - Other health insurance
 - Complex claim requiring extensive review
 - Government directed delay, usually because the provider is being investigated or because of fraud
 - Provider delayed submitting claim
 - Duplicate charges
 - Non-authorized service/no referral
 - Medical necessity not documented
 - DEERS information inaccurate
- The TRICARE Web site refers beneficiaries, who need assistance in completing their claim forms and understanding their EOBs, to their nearest TSC or their nearest BCAC or HBA.
- The claims processors can also assist beneficiaries with any questions pertaining to the EOB.
- If the claims issue has been inappropriately sent to a collection agency, the beneficiary needs to seek assistance from the nearest DCAO.
- If the beneficiary did not pay their co-pay or cost share, explain to them that they need to pay that portion.

Beneficiaries should be advised to carefully check each EOB they receive.

- They should make sure they compare their actual bills from the provider or service against the EOB.
- If they find a charge for something they never received, they should contact the claims processor.
- Incorrect charges can be due to a simple error in the provider's billing, or can be an indication of fraud.

How to Read an Explanation of Benefits (EOB)—Part 1

1. Find the “Learning to Read an Explanation of Benefits (EOB)” guide sheet on page 13-10. Using the first EOB provided on John Smith, take note of the numbered sections on John Smith’s EOB and how it coincides with the guide. We will go over these numbered entries together in order, 1 through 15, and take a look at the information on John Smith’s EOB and how it provides the beneficiary information regarding services or care rendered by his provider.
2. Using the second EOB provided on Jane Smith, answer the following questions:
 - a. What is the date of notice on this EOB?
 - b. What type of care was rendered?
 - c. Who provided the care and how much was billed to TRICARE?
 - d. How much was approved by TRICARE for payment on this care?
 - e. What amount of service rendered was non-covered?
 - f. Who is responsible for paying the deductible?
3. Using the third EOB provided on John Doe, answer the following questions:
 - a. Where is the claim number printed on this EOB?
 - b. Who rendered the care?
 - c. What type of visit was made to the provider?
 - d. How much was billed to TRICARE?
 - e. How much did TRICARE pay for the service rendered?
 - f. How much is the co-payment and who pays this?
 - g. Which TRICARE option is the beneficiary in?
4. Using the last EOB provided on Jane Doe, answer the following questions:
 - a. What is the claim number printed on this EOB?
 - b. Who rendered the care on this beneficiary?
 - c. Is there other health insurance involved?
 - d. How much was billed to TRICARE?
 - e. How much was paid by TRICARE?
 - f. How much was paid by the beneficiary?
 - g. How much more of the deductible is left to be paid by the beneficiary?
 - h. How much went to the catastrophic cap?

Bonus question: Which region does not use PGBA as its claims processor?

Learning to Read an Explanation of Benefits (EOB)

The numbered entries below coincide with the numbered bubbles on the EOB in the preceding page.

1. Identification of the claim processing unit to include address.
2. Defines the explanation of benefits.
3. The Claims Processing Unit's Logo and e-mail address.
4. Date the EOB was printed, the sponsor's SSN and beneficiary's name.
5. The name and mailing address of the beneficiary.
6. Identifies who and where the check was mailed to regarding the claim. If the beneficiary is mailed the check, a check number will appear in the claim summary section, see number 13 below.
7. This is the internal claim number. Each claim is identified by this 13 digit identifier.
8. This section identifies who provided the service and date(s) of the service.
9. This section identifies the types of services provided. This is where the CPT and ICD9 codes are listed.
10. Shows the amount billed by the provider of the service.
11. Shows what the TRICARE allowable charge is.
12. This is the remarks section. Always read the remarks at the bottom of the Explanation of Benefits. It explains how the claim processed.
13. The Claim Summary section identifies the following: Amount billed, amount TRICARE approved and paid out, Non-covered service(s) listed based on dollar amount, how much was paid by the beneficiary up front, what OHI paid if any, what was paid to the provider or to the beneficiary, and the check number identifier if the beneficiary is paid directly by TRICARE.

14. The Beneficiary Liability Summary section shows what the beneficiary has paid or is yet to pay to include: Deductible, Co-pay, Cost share, and Patient Responsibility. If the beneficiary owes money to the provider, the provider will directly bill the beneficiary. It is always best for the beneficiary to wait for the EOB to ensure the correct amount was paid by TRICARE before paying any outstanding amounts directly to the provider.
15. The Benefit Period Summary section shows the Fiscal year beginning and Enrollment year beginning if the beneficiary is Prime. The Enrollment Year Beginning is for Retirees and others who pay for their Prime enrollment; it is used to compute the Catastrophic Cap. Once the initial enrollment year is completed, the Catastrophic Cap is then tracked on a Fiscal Year basis. This section also shows the Deductible amounts applied for an Individual and Family during the Fiscal Year.

TRICARE Fundamentals Course

Module 13: Claims & Appeals

1 PGBA, LLC
TRICARE SOUTH REGION
P.O. BOX 7032
CAMDEN, SC 29020-7032

2 **TRICARE EXPLANATION OF BENEFITS**
This is a statement of the action taken on your TRICARE claim.
Keep this notice for your records.

3 **HUMANA** •
Military Healthcare Services
www.humana-military.com

4 **Date of Notice:** October 27, 2004
Sponsor SSN: ###-##- 7890
Sponsor Name: JOHN SMITH
Beneficiary Name: JOHN SMITH

Benefits were payable to:

5 JOHN SMITH
2468 25TH STREET
NICEVILLE FL 12345

6 XYZ REGIONAL HEALTHCARE SYS
995 CHRISTMAS LANE
FORT WALTON BEACH FL 12345

7 **Claim Number:** 987654321-00-00

8 Service Provided By Date of Services	9 Services Provided	10 Amount Billed	11 TRICARE Approved	12 See Remarks
XYZ REGIONAL HEALTHCARE SYS				
10/19/2004	001 (S1250)	5.50	5.50	1, 2, 3
10/19/2004	001 (S1306)	34.00	3.00	4, 1, 2, 3
10/19/2004	001 (S1450)	104.00	104.00	1, 2, 3
Totals:		143.50	112.50	

13 Claim Summary	14 Beneficiary Liability Summary	15 Benefit Period Summary
Amount Billed: 143.50	Deductible: 91.98	Fiscal Year Beginning:
TRICARE Approved: 112.50	Copayment: 0.00	October 01, 2004
Non-Covered: 31.00	Cost Share: 0.00	Individual Family
Paid by Beneficiary: 0.00	Patient Responsibility 97.11	Deductible: 150.00 150.00
Other Insurance: 0.00		Catastrophic Cap: 155.13
Paid to Provider: 15.39		
Paid to Beneficiary: 0.00		
Check Number:		

12 **Remarks:**

1 - HUMANA AND PGBA ARE MAKING TRICARE EASIER. FOR ONLINE CLAIM AND REFERRAL STATUS
ELIGIBILITY AND MUCH MORE, VISIT WWW.HUMANA-MILITARY.COM AND WWW.MYTRICARE.COM

2 - \$155.13 HAS BEEN APPLIED TOWARD THE FISCAL YEAR CATASTROPHIC CAP OF \$3,000.00

3 - TRICARE PRIME CAN SAVE YOU MONEY. LEARN HOW TO ENROLL BY CALLING 1-800-444-5445

4 - THE AMOUNT ALLOWED WAS THE LESSER OF BILLED CHARGES, CONTRACTED RATE, STATE PREVAILING
OR THE TRICARE MAXIMUM ALLOWABLE CHARGE

1-800-403-3950

THIS IS NOT A BILL

If you have questions regarding this notice, please call or write us at the telephone number/address listed above.



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Module 13: Claims & Appeals

1 PG&A, LLC
TRICARE SOUTH REGION
P.O. BOX 7032
CAMDEN, SC 29020-7032

2 **TRICARE EXPLANATION OF BENEFITS**
This is a statement of the action taken on your TRICARE claim.
Keep this notice for your records.

3 **HUMANA** •
Military Healthcare Services

www.humana-military.com

4 **Date of Notice:** October 24, 2004
Sponsor SSN: ### - ##- 7845
Sponsor Name: JANE SMITH
Beneficiary Name: JANE SMITH

Benefits were payable to:

5 JANE SMITH
123 S CHRISTMAS LANE
AROUNDTHEBEND, SC 203156

6 **TRY CARE SOUTH INC**
PO BOX 567
OVERTHEHILL, SC 203156

7 **Claim Number:** 345678901-00-00

8 Service Provided By Date of Services	9 Services Provided	10 Amount Billed	11 TRICARE Approved	12 See Remarks
TRY CARE SOUTH INC				

10/9/2004	1 Office/outpatient visit, est (99214)	95.00	59.26	1, 2, 3, 4
Totals:		95.00	59.26	

13 Claim Summary	14 Beneficiary Liability Summary	15 Benefit Period Summary									
Amount Billed: 95.00	Deductible: 59.26	Fiscal Year Beginning: October 01, 2004 <table border="0"> <tr> <td></td> <td>Individual</td> <td>Family</td> </tr> <tr> <td>Deductible:</td> <td>59.26</td> <td>59.26</td> </tr> <tr> <td>Catastrophic Cap:</td> <td></td> <td>59.26</td> </tr> </table>		Individual	Family	Deductible:	59.26	59.26	Catastrophic Cap:		59.26
	Individual		Family								
Deductible:	59.26		59.26								
Catastrophic Cap:			59.26								
TRICARE Approved: 59.26	Copayment: 0.00										
Non-Covered: 35.74	Cost Share: 0.00										
Paid by Beneficiary: 0.00											
Other Insurance: 0.00											
Paid to Provider: 0.00											
Paid to Beneficiary: 0.00											
Check Number:											

12 **Remarks:**

- 1 - CHARGES ARE MORE THAN ALLOWABLE AMOUNT
- 2 - AMOUNT ALLOWED IS BASED ON A DISCOUNT AGREEMENT
- 3 - \$59.26 HAS BEEN APPLIED TOWARD THE FISCAL YEAR CATASTROPHIC CAP OF \$3,000.00
- 4 - HUMANA AND PG&A ARE MAKING TRICARE EASIER. FOR ONLINE CLAIM AND REFERRAL STATUS, ELIGIBILITY AND MUCH MORE, VISIT WWW.HUMANA-MILITARY.COM AND WWW.TRICARE.COM

1-800-403-3950
THIS IS NOT A BILL
If you have questions regarding this notice, please call or write us at the telephone number/address listed above.



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Module 13: Claims & Appeals

PGBA, LLC
 TRICARE NORTH REGION
 P.O. BOX 870140
 Surfside Beach, SC 29587

TRICARE EXPLANATION OF BENEFITS
 This is a statement of the action taken on your TRICARE claim.
 Keep this notice for your records.

Health Net[®]
 Federal Services
 www.HealthNetFederalServices.com

JOHN DOE
 123 25TH ST
 WASHINGTON, DC 20123

Whats-Up EMERGENCY ASSOCIATES
 PO BOX 1234
 WASHINGTON, DC 201113

Claim Number: 123456789-00-00

Service Provided By Date of Services	Services Provided	Amount Billed	TRICARE Approved	See Remarks
WHATS-UP EMERGENCY ASSOCIATES 10/22/2004	001 Emergency dept visit (99284)	264.00	84.09	1, 2, 3, 4
Totals:		264.00	84.09	

Claim Summary	Beneficiary Liability Summary	Benefit Period Summary
Amount Billed: 264.00	Deductible: 0.00	Fiscal Year Beginning:
TRICARE Approved: 84.09	Copayment: 30.00	October 01, 2004
Non-Covered: 179.91	Cost Share: 0.00	Individual Family
Paid by Beneficiary: 0.00	Patient Responsibility 0.00	Deductible: 0.00 0.00
Other Insurance: 0.00		Catastrophic Cap: 30.00
Paid to Provider: 54.09		
Paid to Beneficiary: 0.00		
Check Number:		

Remarks:


- 1 - CHARGES ARE MORE THAN ALLOWABLE AMOUNT
- 2 - HUMANA AND PGBA ARE MAKING TRICARE EASIER. FOR ONLINE CLAIM AND REFERRAL STATUS ELIGIBILITY AND MUCH MORE, VISIT WWW.HUMANA-MILITARY.COM AND WWW.MYTRICARE.COM
- 3 - \$30.00 HAS BEEN APPLIED TOWARD THE CATASTROPHIC CAP OF \$3,000.00
- 4 - AMOUNT ALLOWED IS BASED ON A DISCOUNT AGREEMENT

1-800-403-3950
THIS IS NOT A BILL
 If you have questions regarding this notice, please call or write us at the telephone number/address listed above.

TRICARE
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Module 13: Claims & Appeals

<p>1 PG&A, LLC TRICARE SOUTH REGION P.O. BOX 7032 CAMDEN, SC 29020-7032</p>	<p>2 TRICARE EXPLANATION OF BENEFITS This is a statement of the action taken on your TRICARE claim. Keep this notice for your records.</p>																																	
<p>3 HUMANA • Military Healthcare Services www.humana-military.com</p>	<p>4 Date of Notice: October 24, 2004 Sponsor SSN: ### - ## - 1234 Sponsor Name: JANE DOE Beneficiary Name: JANE DOE</p>																																	
<p>5 JANE DOE 123 ST NICK DR ATLANTA, GA 12345</p>	<p>6 WALKTHEWALK MEDI GROUP PO BOX 12345 ATLANTA, GA 24681</p>																																	
<p>7 Claim Number: 213456789-00-00</p>																																		
<table border="1" style="width: 100%;"><thead><tr><th>8 Service Provided By/ Date of Services</th><th>9 Services Provided</th><th>10 Amount Billed</th><th>11 TRICARE Approved</th><th>12 See Remarks</th></tr></thead><tbody><tr><td colspan="5">WALKTHEWALK MEDI GROUP</td></tr><tr><td>9/30/2004</td><td>1 Office/outpatient visit, est (99212)</td><td>49.00</td><td>32.80</td><td>1, 2, 3, 4</td></tr><tr><td colspan="2">Totals:</td><td>49.00</td><td>32.80</td><td></td></tr></tbody></table>		8 Service Provided By/ Date of Services	9 Services Provided	10 Amount Billed	11 TRICARE Approved	12 See Remarks	WALKTHEWALK MEDI GROUP					9/30/2004	1 Office/outpatient visit, est (99212)	49.00	32.80	1, 2, 3, 4	Totals:		49.00	32.80														
8 Service Provided By/ Date of Services	9 Services Provided	10 Amount Billed	11 TRICARE Approved	12 See Remarks																														
WALKTHEWALK MEDI GROUP																																		
9/30/2004	1 Office/outpatient visit, est (99212)	49.00	32.80	1, 2, 3, 4																														
Totals:		49.00	32.80																															
<table border="1" style="width: 100%;"><thead><tr><th>13 Claim Summary</th><th>14 Beneficiary Liability Summary</th><th>15 Benefit Period Summary</th></tr></thead><tbody><tr><td>Amount Billed: 49.00</td><td>Deductible: 32.80</td><td>Fiscal Year Beginning:</td></tr><tr><td>TRICARE Approved: 32.80</td><td>Copayment: 0.00</td><td>October 01, 2004</td></tr><tr><td>Non-Covered: 16.20</td><td>Cost Share: 0.00</td><td>Individual Family</td></tr><tr><td>Paid by Beneficiary: 0.00</td><td></td><td>Deductible: 32.80 32.80</td></tr><tr><td>Other Insurance: 0.00</td><td></td><td>Catastrophic Cap: 32.80</td></tr><tr><td>Paid to Provider: 0.00</td><td></td><td>Enrollment Year Beginning:</td></tr><tr><td>Paid to Beneficiary: 0.00</td><td></td><td>August 01, 2004</td></tr><tr><td>Check Number:</td><td></td><td>Individual Family</td></tr><tr><td></td><td></td><td>POS Deductible: 32.80 32.80</td></tr><tr><td></td><td></td><td>Prime Cap: 32.80</td></tr></tbody></table>		13 Claim Summary	14 Beneficiary Liability Summary	15 Benefit Period Summary	Amount Billed: 49.00	Deductible: 32.80	Fiscal Year Beginning:	TRICARE Approved: 32.80	Copayment: 0.00	October 01, 2004	Non-Covered: 16.20	Cost Share: 0.00	Individual Family	Paid by Beneficiary: 0.00		Deductible: 32.80 32.80	Other Insurance: 0.00		Catastrophic Cap: 32.80	Paid to Provider: 0.00		Enrollment Year Beginning:	Paid to Beneficiary: 0.00		August 01, 2004	Check Number:		Individual Family			POS Deductible: 32.80 32.80			Prime Cap: 32.80
13 Claim Summary	14 Beneficiary Liability Summary	15 Benefit Period Summary																																
Amount Billed: 49.00	Deductible: 32.80	Fiscal Year Beginning:																																
TRICARE Approved: 32.80	Copayment: 0.00	October 01, 2004																																
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		POS Deductible: 32.80 32.80																																
		Prime Cap: 32.80																																
<p>12 Remarks:</p> <p>1 - CLAIM PAID UNDER POINT OF SERVICE OPTION</p> <p>2 - AMOUNT ALLOWED IS BASED ON A DISCOUNT AGREEMENT</p> <p>3 - \$32.80 HAS BEEN APPLIED TOWARD THE CATASTROPHIC CAP OF \$1,000.00</p> <p>4 - HUMANA AND PG&A ARE MAKING TRICARE EASIER. FOR ONLINE CLAIM AND REFERRAL STATUS ELIGIBILITY AND MUCH MORE, VISIT WWW.HUMANA-MILITARY.COM AND WWW.MYTRICARE.COM</p>																																		
<p style="text-align: center;">1-800-403-3950</p> <p style="text-align: center;">THIS IS NOT A BILL</p> <p style="text-align: center;">If you have questions regarding this notice, please call or write us at the telephone number/address listed above.</p>																																		
																																		

How to Read an Explanation of Benefits (EOB)—Part 2

Directions: Now that you have had some practice in reading an EOB, use the Explanation of Benefits on page 13-17 and answer the following questions for each numbered scenario below. This is a group exercise. The instructor will provide additional guidance.

1. Find Colonel Mustard's EOB and answer the following:
 - a. What is the name of the provider?
 - b. When was the date of care?
 - c. How much was billed by the provider for the care rendered?
 - d. How much did TRICARE pay for this care and who received the check?
 - e. Is the beneficiary financially liable for any amount? Why or why not?
 - f. Is the beneficiary a retiree or active duty? How do you know this?
 - g. How much of the deductible has been paid to date?
 - h. Explain what happens when the catastrophic cap is reached?

2. Locate Holy Smokes Hospital EOB and answer the following:
 - a. What is the name of the patient?
 - b. When was the date of service for this care?
 - c. What is the description of the service rendered?
 - d. What are the last five digits of the claim number?
 - e. How much was billed for the care rendered?
 - f. How much was allowed by TRICARE and why?
 - g. What is the next recourse for the beneficiary?
 - h. The sponsor number is also known as the _____ number.
 - i. An EOB can also be used as a _____ certificate to show providers the amount of _____ deductible that has been paid to date.
 - j. Who actually received this EOB, the patient or the hospital? How do you know?

TRICARE Fundamentals Course
Module 13: Claims & Appeals



TRICARE SUMMARY
PAYMENT VOUCHER
B399161787 V

TRICARE EXPLANATION OF BENEFITS

Administered by: Health Net Federal Services, Inc.

This is a statement of the action taken on your TRICARE claim. Keep this notice of your records. If you have any questions regarding your claim payment please call the appropriate number:

Beneficiaries: 1-800-404-0110

Providers: 1-800-404-3117

COLONEL MUSTARD
309 CLUE LANE
SEATTLE WA 98063

WELBY, MARCUS MD
07/08/03

All Communications regarding these claims must reference the claim number.

THIS IS NOT A BILL

PATIENT NAME COLONEL MUSTARD		SPONSOR NO 399161787		PATIENT ACC # 55555555		SPONSOR COLONEL MUSTARD	
PROVIDER WELBY, MARCUS MD		CLAIM NO 2003189 53 49996		MOD NO TYP 01 05		BILLED 55.00	
SERVICE DATES 02/01/03-02/01/03		PROC 81000		TOTAL 55.00		ALLOWED CODE 4.43 003	
OTHER INS. ALLOWED 0.00		OTHER INS. PAID 0.00		REDUCTION DAYS 0		REDUCTION AMOUNT 0.00	
DEDUCT 0.00		COST-SHARE/ COPAYMENT 0.00		TOTAL PAYABLE 4.43		INTEREST PAID 0.00	
						PAID BY PATIENT 0.00	
						NET PAYMENT 4.43	

REMARKS

PAYMENT HAS BEEN MADE TO THE PROVIDER OF CARE.
\$1,146.53 HAS BEEN ACCUMULATED TOWARD THE CHAMPUS FISCAL YEAR
CATASTROPHIC CAP OF \$3,000.00 FOR THE FISCAL YEAR '03.
TOTAL BENEFICIARY LIABILITY IS \$5.09.
ACCUMULATED INDIVIDUAL DEDUCTIBLE FOR FISCAL YEAR '03 IS \$139.13.
ACCUMULATED FAMILY DEDUCTIBLE FOR FISCAL YEAR '03 IS \$139.13.

CODE 003

IF YOU ARE NOT SATISFIED WITH OUR DETERMINATION, YOU HAVE THE RIGHT TO REQUEST
A
REVIEW WITHIN 90 DAYS OF THE DATE OF THIS NOTICE. SEE ITEM FIVE ON REVERSE OF
PAGE 1.

***** VOUCHER SUMMARY *****

TOTAL PAYABLE
4.43

NET PAYMENT
4.43

IMPORTANT NOTICE

1) THIS NOTICE CAN BE USED:

- A. As a deductible certificate to show your providers the amount of the outpatient deductible met as of the date of this notice.
- B. As a record of bills paid or denied (if you submitted other medical expenses not shown on this form, you will receive a separate notice.)
- C. To collect other insurance. This notice may be used to claim benefits from a secondary insurance policy. Since the insurance company may keep this notice, it is advisable that you keep a record of this information.

IF YOU NEED MORE INFORMATION:

- Check your TRICARE handbook.
- See the Health Benefits Advisor or Health Care Finder at the nearest Uniformed Services medical facility.
- Always give your Sponsor's Social Security number when writing about your claim.
- If inquiring about this claim, please provide the claim number located on the front of this form.
- Contact us at the telephone number shown on the front of this form.
- Written inquiries except Appeals (see #4) and Grievances (see #10) should be mailed to the following address:

Foundation Health Federal Services
TRICARE Services, Correspondence Unit
P.O. Box 7973
Madison, WI 53707-7973

2) TIME LIMIT FOR FILING CLAIMS:

For services received:	File Claims By:
1 Jan 93-31 Dec 93	31 Dec 94
1 Jan 94 & after	1 year after Date of Service

All claims for benefits submitted under TRICARE for dates of service prior to January 1, 1994 must be filed with the appropriate TRICARE contractor no later than December 31 of the calendar year immediately following the year in which the service or supply was provided. For services on and after January 1, 1994, all claims must be filed with the appropriate TRICARE contractor no later than one year from the date of service or, the date of discharge in the case of inpatient care.

If your claim was denied because it was not filed on time and you believe you were not at fault, contact us or your Health Benefits Advisor for assistance. In limited circumstances, exceptions may be made.

5) IF PAYMENT NOT BASED ON THE FULL AMOUNT BILLED:

The amount TRICARE may pay is limited by law to the lowest of:

- A. The TRICARE Maximum Allowable Charge; i.e. the charge made 80 percent of the time by physicians or suppliers in the country for similar services during the base year adjusted by where the services were rendered; or
- B. Prevailing charge; i.e. the charge made 80 percent of the time by physicians or suppliers in the state for similar services during the base year; or
- C. The amount the provider actually charges for the service or supply; or
- D. The fiscal year 1988 prevailing charge adjusted by the Medicare Economic Index (MEI); or
- E. The discounted charge that a provider has agreed to accept under a special program approved by the Directory, TRICARE.

6) PATIENT'S SHARE OF THE COST FOR AUTHORIZED CARE:

Inpatient Benefits *See remarks on front.

Outpatient Benefits:

Active duty family members of sponsor E-4 and below:	First \$50 of allowable charges incurred by a patient each fiscal year (1 October-30 September) not to exceed \$100 per family plus 20% of allowable charges after deductible has been paid.
Active duty family members of sponsor E-5 and above:	First \$150 of allowable charges incurred by a patient each fiscal year (1 October-30 September) not to exceed \$300 per family plus 20% of allowable charges after deductible has been paid.
Former spouses, non-active duty members and their families:	First \$150 of allowable charges incurred by a patient each fiscal year (1 October-30 September) not to exceed \$300 per family plus 25% of allowable charges after deductible has been paid.

Claim payments are subject to the provision that the beneficiary cost-share is collected by the provider. The provider's failure to collect the cost-share can be considered a false claim and/or may result in reduction of payment.

7) SPONSOR, PATIENT, OR DEPENDENT NOT ENROLLED OR NOT ELIGIBLE ON DEERS:

If the Defense Enrollment Eligibility Reporting System (DEERS) indicates that the sponsor, patient and/or

TRICARE Fundamentals Course

Module 13: Claims & Appeals

3) TYPE OF SERVICE CODES:

First Position:

A = Ambulatory surgery cost-shared as inpatient (Active Duty family members only)	N = Outpatient cost-shared as inpatient
I = Inpatient	O = Outpatient Care Other
M = Outpatient maternity care cost-shared as inpatient	P = Outpatient partial psychiatric hospitalization care cost-shared as inpatient

Second Position:

1 = Medical Care	A = DME Rental/Purchase
2 = Surgery	B = Drugs
3 = Consultation	C = Ambulatory Surgery
4 = Diagnostic/Therapeutic X-Ray	D = Hospice
5 = Diagnostic Laboratory	E = Second Opinion on Elective Surgery
6 = Radiation Therapy	F = Maternity
7 = Anesthesia	G = Dental
8 = Assistance at Surgery	H = Mental Health Care
9 = Other Medical Service	I = Ambulance
	J = Program for Persons with Disabilities

4) YOUR RIGHT TO APPEAL THIS INITIAL DETERMINATION:

If you disagree with the determination on your claim, you have the right to request a reconsideration. Your **SIGNED** written request must state the specific matter with which you disagree and **MUST** be mailed to the following address no later than ninety (90) days from the date of this notice. If the postmark on the envelope is not legible, then the date of receipt is deemed the date of filing. Include a copy of this notice. On receiving your request, all TRICARE claims for the entire course of treatment will be reviewed.

TRICARE Appeals
ATTN: APPEALS
P.O. Box 8370
Madison, WI 53708-8370

Should a beneficiary unknowingly receive services for non-TRICARE benefits, the beneficiary will not be held responsible for the charges.

dependent is not enrolled or eligible for TRICARE benefits, you should contact your Health Benefits Advisor or your service personnel office. Future claims will be denied if you are not enrolled in DEERS. If the claim was denied and the sponsor has recently gone on active duty, resubmit the claim with a copy of the duty orders and a photocopy of the patient's identification (ID) card or (parent's ID for dependent children under 10 years of age). If the sponsor is retired, resubmit the claim with the sponsor's retirement papers and a photocopy of the patient's (ID) card. If the sponsor is deceased, report to any service personnel office to get enrolled or call the appropriate number listed below.

8) IDENTIFICATION CARD (ID) OR ELIGIBILITY EXPIRED ON DEERS:

The Defense Enrollment Eligibility Reporting System (DEERS) indicates that the patient's ID card or eligibility has expired. To get a new ID card or extend eligibility, if sponsor is active duty, report at once to any parent service personnel office; if sponsor is retired or deceased, contact any service personnel office. If the claim was denied, when the patient obtains a current ID card, resubmit the claim with a photocopy of the new ID card (both front and back sides). In an emergency, call the appropriate number listed below.

FOR DEERS INFORMATION CALL:

CALIFORNIA.....1-800-334-4162	HAWAII & Alaska. 1-800-527-5602	
ALL OTHER STATES.....1-800-538-9552		

9) BENEFICIARY NOTICE

Please review the services shown on the front side of this TRICARE Explanation of Benefits. If you find that payment consideration has been made for any services that you did not receive; or that services were provided by a health care professional that you did not see, please call the FRAUD AND ABUSE number at 1-800-977-6761.

10) TO FILE A GRIEVANCE:

If you become dissatisfied with the quality, timeliness or accessibility of care, you may file a grievance. Mail your written grievance to:

FHFS--QM Department
Attn: Grievances
3600 Port of Tacoma Road, Suite 505
Tacoma, WA 98424

TRICARE Fundamentals Course
Module 13: Claims & Appeals



Northwest
P.O. BOX 7973
MADISON, WI 53707-7973

TRICARE SUMMARY
PAYMENT VOUCHER
P910567267989020000V

TRICARE EXPLANATION OF BENEFITS

Administered by: Health Net Federal Services, Inc.

This is a statement of the action taken on your TRICARE claim. Keep this notice of your records. If you have any questions regarding your claim payment please call the appropriate number:
Beneficiaries: 1-800-404-0110
Providers: 1-800-404-3117


HOLY SMOKES HOSPITAL
2811 TIETON DR
YAKIMA WA 98902-3761

HOLY SMOKES HOSPITAL
05/01/03


All Communications regarding these claims must reference the claim number.

THIS IS NOT A BILL											
PATIENT NAME PAUL BUNYAN				SPONSOR NO 001122334				PATIENT ACC # 43039049309			
SPONSOR NAME PAUL BUNYAN				SERVICE DATES 04/01/03-04/02/03				CLAIM NO 2003121 53 49992			
PROVIDER HOLY SMOKES HOSPIT				DESCRIPTION AUTHORIZE PRIV RM				BILLED 300.00 ALLOWED CODE 0.00 236			
DRG	DX1	DX2	DX3	DX4	PRC1	PRC2	PRC3	DSCH ST	YOB	SEX	OUTLIER
	DX5	DX6	DX7	PRC4	PRC5	PRC6					
	DX8	DX9									
000	56213							01	45	M	NONE
PAID BY PATIENT				OTHER INS. PAID							
0.00				100.00							
BILLED				COST-SHARE/ COPAYMENT				INTEREST PAID			
300.00				0.00				0.00			
REMARKS											
<p>\$1,394.27 HAS BEEN ACCUMULATED TOWARD THE CHAMPUS FISCAL YEAR CATASTROPHIC CAP OF \$3,000.00 FOR THE FISCAL YEAR '03.</p> <p>CODE 236 OUR RECORDS INDICATE THAT YOU HAVE TWO OR MORE HEALTH INSURANCES THAT ARE PRIMARY TO TRICARE. YOUR CLAIM WAS DENIED BECAUSE WE DID NOT RECEIVE EXPLANATIONS OF BENEFITS (EOBS) FROM ALL OF YOUR INSURANCES FOR THE CHARGES SUBMITTED TO TRICARE.</p>											
VOUCHER SUMMARY											
TOTAL PAYABLE						NET PAYMENT					
0.00						0.00					

Appeals



Appeals



- Appeals process
- Who is able to appeal?
- What can be appealed?
- What cannot be appealed?

Appeals Process

To appeal means to ask the TRICARE contractor or TRICARE Management Activity (TMA) for a review of the decision to deny a beneficiary's claim. The appeals process varies, depending on whether the denial of benefits involves:

- Medical necessity determination
- Factual determination
- Provider sanction
- Dual-eligible determination

All initial denials and appeal denials explain how, where, and by when, to file the next level of appeal.

Medical Necessity Determinations

Medical necessity determinations are based solely on medical necessity:

- Whether, from a medical point of view, the care is appropriate, reasonable, and adequate for the beneficiary's condition
- It may be necessary to show medical necessity for inpatient, outpatient, and specialty care
- Generally, determinations relating to mental health benefits are considered medical necessity determinations

There are procedures for expedited and non-expedited appeals.

- Expedited
 - Expedited is primarily used for medical urgency where the health of an individual is at stake.
 - There are expedited procedures for appealing decisions denying requests for:
 - Preauthorization of services
 - Requests for continued inpatient stays
 - If an expedited appeal is available, the initial denial and appeal denial decisions will fully explain how to file an expedited appeal.
 - The answer to an expedited appeal is usually provided by phone.
- Non-expedited
 - The beneficiary needs to send a letter to the regional contractor at the address specified in the notice of the beneficiary's right to appeal, included in their EOB or other decision:
 - The letter must be postmarked or received within 90 days of the date on the EOB or other decision.
 - It should include a copy of the EOB or other decision, and all documents that support the position that the service should not be denied.
 - If the beneficiary does not have all of the supporting documents, he or she should state in the letter the intention to submit additional information
 - The beneficiary should make copies of the letter and all contents.
 - The regional contractor will review the case and issue a reconsideration decision:
 - If the beneficiary disagrees with a reconsideration decision, the next level of appeal is the national quality monitoring contractor.
 - Send a letter to the national quality monitoring contractor:
 - The letter must be postmarked or received within 90 days of the date on the reconsideration decision.
 - A copy of the reconsideration decision and any supporting documents not previously submitted must be included in the letter.
 - If the beneficiary does not have all of the supporting documents, it should state in the letter that the beneficiary intends to submit additional information.
 - Beneficiary should keep copies of all paperwork.
 - The national quality monitoring contractor will review the case and issue a second reconsideration decision.

- If the amount in dispute is less than \$300, the reconsideration decision by the national quality monitoring contractor is final:
 - If the beneficiary disagrees, and the disputed services are \$300 or more, the beneficiary can request TMA to schedule an independent hearing.
 - The address for TMA is as follows:
TRICARE Management Activity
Appeals, Hearings, and Claims Collection Division
16401 E. Centretech Parkway
Aurora, Colorado 80011-9066

Factual Determinations

Factual determinations involve issues other than medical necessity. Some examples of factual determinations include the following:

- Coverage issues (i.e., determining whether the service is covered under TRICARE policy or regulation)
- Foreign claims and denial of a provider's request for approval as a TRICARE authorized provider

The appeal process for factual determinations includes the following:

- Send a letter to the regional contractor, or to the address specified in the notice of the beneficiary's right to appeal, included in the beneficiary's EOB or other decision:
 - The letter must be postmarked or received within 90 days of the date on the EOB.
 - It must include a copy of the EOB or other decision and any supporting documents not previously submitted.
 - If the beneficiary does not have all of the supporting documents, it must be stated in the letter that the beneficiary intends to submit additional information.
 - The beneficiary should be encouraged to keep copies of all paperwork.
- If the amount in dispute is less than \$50, the reconsideration decision from the regional contractor is final:
 - If the beneficiary disagrees, and if \$50 or more is in dispute, the beneficiary may request a formal review from TMA.
 - If the beneficiary disagrees with a reconsideration decision, or with the initial determination from TMA, and if notice of the beneficiary's right to appeal any decision identifies TMA as the next level of appeal, the beneficiary may ask TMA to review the case again and issue a formal review decision.

- Send a letter to TMA:
TRICARE Management Activity
Appeals, Hearings, and Claims Collection Division
16401 E. Centretch Parkway
Aurora, Colorado 80011-9066
 - The letter must be postmarked or received within 60 days of the date on the initial determination or reconsideration decision.
 - The beneficiary should include copies of the determination or reconsideration decision, as well as any supporting documents not previously submitted.
 - If the beneficiary does not have all of the supporting documents, he or she should state the intention to submit additional information.
 - Encourage the beneficiary to keep copies of what is sent.
- TMA will review the case and issue a formal review decision:
 - If the amount in dispute is less than \$300, the formal review decision by TMA is final.
 - If the beneficiary still disagrees, and the disputed services are \$300 or more, the beneficiary can request TMA schedule an independent hearing.

Provider Sanction Determinations

Provider sanction determinations occur when providers are expelled from TRICARE.

Providers may be sanctioned by TRICARE because of the following:

- Failure to maintain credentials
- Provider fraud
- Abuse
- Conflict of interest or other reasons

Only the provider or his or her representative can appeal. If the sanctions are appealed, an independent hearing officer will conduct a hearing administered by the TMA Appeals, Hearings, and Claims Collection Division in Aurora, Colorado.

Dual-eligible Beneficiary Determinations

Dual-eligible beneficiary determinations apply to beneficiaries who are eligible for Medicare and TRICARE benefits because of age, disability, or end-stage renal disease.

- If the denial is appealed to Medicare, the Medicare appeal decision is final.
 - If however, a Medicare appeal results in some payment by Medicare, the services and supplies covered by Medicare will be considered for coverage by TRICARE.
 - Services and supplies considered for coverage by TRICARE, if denied, are subject to the factual appeal process.
 - Services and supplies denied payment by Medicare will not be considered for coverage by TRICARE if the Medicare denial of payment can be appealed through the Medicare appeal process.

Who is Able to Appeal?

- Any TRICARE beneficiary, or a parent or guardian of a beneficiary who is under 18 years of age
- The guardian of a beneficiary who is not competent to act in his or her own behalf
- A health care provider who has been
 - Denied approval
 - Suspended, excluded, or terminated as a TRICARE-authorized provider
- A health care provider who participates in TRICARE
 - Providers who participate in TRICARE accept the TRICARE-allowable charge as their full fee.
 - Providers who do not participate in TRICARE and network providers cannot file appeals.
- A representative appointed in writing by a beneficiary or provider
 - Certain individuals may not serve as representatives due to a conflict of interest:
 - An officer (member of a uniformed services legal office)
 - HBA
 - Employee of the United States (employee of a uniformed services legal office or an HBA/BCAC)
 - Exception: that person is representing an immediate family member.
- The appealing party must be able to prove he or she is eligible for TRICARE benefits



What Can Be Appealed?

- The facts of the beneficiary's case
 - Diagnosis
 - Necessity to be an inpatient
- Denial of preauthorization for services, including mental health
- Termination of treatments or services that have been previously authorized
- Denial of TRICARE payment for services or supplies received
- Termination of TRICARE payment for continuation of services or supplies that were previously authorized
- Denial of a provider's request for approval as a TRICARE-authorized provider or expelling a provider from TRICARE

What Cannot Be Appealed?

The following are examples of what cannot be appealed:

- The amount that the TRICARE contractor determines to be the allowable charge for a particular medical service
 - The beneficiary may ask the TRICARE contractor for an allowable charge review—not an appeal.
- The decision by TRICARE, or its contractors, to ask the beneficiary for more information before action is taken on the beneficiary's claim or appeal request
- Beneficiaries cannot appeal decisions relating to the status of TRICARE providers:
 - Although a beneficiary may want to receive care, or already has received care, from a particular provider, the beneficiary cannot appeal a decision that denies the provider authorization to be a TRICARE provider, or a decision that suspends, excludes, or terminates the provider.
 - The provider in question may appeal in his or her own behalf.
- Decisions relating to eligibility as a TRICARE beneficiary
 - Eligibility is determined by enrollment in the DEERS:
 - Beneficiaries must appeal decisions regarding their eligibility through their branch of Service.



Appeals

- **Requesting a formal appeal**
- **TRICARE Prime Remote appeals**
- **Where to get additional information for beneficiaries**

Requesting a Formal Hearing

After all other steps have been taken; a beneficiary wanting a formal hearing must send his or her request to the following:

TRICARE Management Activity
Appeals, Hearings and Claims Collection Division
16401 E. Centrectech Parkway
Aurora, Colorado 80011-9066.

The request must be:

- Postmarked within 60 days of the decision being appealed
- Include a copy of the decision being appealed and any supporting documents not previously submitted
- If the beneficiary does not have all of the supporting documents, the request should state that the intention to submit additional information.
- Encourage the beneficiary to keep copies of anything sent.

An independent hearing officer will conduct the hearing at a location convenient to both the requesting party and the Government. The hearing officer will issue a recommended decision, and the TMA director (or designee) or the Assistant Secretary of Defense for Health Affairs will issue the final decision.

TRICARE Prime Remote Appeals

In the event a request for specialty care is not approved, the active duty service member (ADSM) will be informed of the decision. The ADSM may appeal this decision by first contacting the MMSO Service Point of Contact (SPOC). ADSMs, their primary care manager, or other provider (if they do not have a primary care manager) may send additional written information or documentation to support the ADSM's request for specialty care to the SPOC.

If the request is denied on appeal, the ADSM may appeal one more time to the Surgeon General or senior medical officer of his or her respective Service. The address for this second appeal will be provided to the ADSM following a denial of the first appeal.

DoD Active Duty Service Members

ADSMs from the Army, Navy, Air Force, and Marine Corps may contact their SPOC at 1-888-MHS-MMSO (1-888-647-6676). Send written inquiries to the following:

(Insert branch of Service) Point of Contact
Military Medical Support Office (MMSO)
P.O. Box 886999
Great Lakes, IL 60088-6999

United States Public Health Service (USPHS) and National Oceanic and Atmospheric Administration (NOAA) members may contact their Beneficiary Medical Program SPOC at 1-800-368-2777 option 2.

Coast Guard members may call 1-800-9HBA-HBA (1-800-942-2422).

Where to Get Additional Information for Your Beneficiaries

If you cannot answer beneficiaries' questions about their denials, direct them to the following:

- The BCAC at the nearest MTF, if you are from a Reserve component unit
- BCAC at the TRICARE Regional Office or TRICARE Area Office
- Regional TRICARE contractor
- The local TSC
- Or write to the TMA Appeals, Hearings, and Claims Collection Division, 16401 E. Centretch Parkway, Aurora, Colorado 80011-9066

Answer: Beneficiaries must:

- Meet all the required deadlines
- Send appeals in writing with signatures
- Include copies of all supporting documents in their appeal. If they do not have the paperwork available, they should send their letter within the deadline and note that more information will be sent.
- Keep copies of everything.

Claims Processors

North Region

Location	Name	Address	City	State	ZIP	Telephone
Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, and West Virginia	Health Net Federal Services, Inc. c/o PGBA, LLC /TRICARE	PO BOX 870140	Surfside Beach	SC	29587-9740	877-874- 2273
North Carolina, Southern Virginia						
Illinois, Indiana, Kentucky, Michigan, Missouri (St. Louis area), Ohio, Tennessee (only those counties in Tennessee surrounding Ft. Campbell), Wisconsin						

South Region

Location	Name	Address	City	State	ZIP	Telephone
Alabama, Mississippi, Tennessee (excluding the Ft. Campbell area), Louisiana, Arkansas	TRICARE South Region Claims Department	PO BOX 7031	Camden	SC	29020-7031	800-403-3950
Oklahoma, Texas (except William Beaumont catchment area in El Paso and Cannon AFB, NM service are ZIP codes that fall in Texas)						

West Region

Location	Name	Address	City	State	ZIP	Telephone
Arizona Colorado, Idaho, Iowa, Kansas, Minnesota, Missouri (except St. Louis area), Montana, Nebraska, Nevada, New Mexico, North Dakota, South Dakota, Utah, Wyoming	West Region Claims	PO BOX 77028	Madison	WI	53707-7028	888-915-4001
California, Hawaii, Oregon, Washington, Alaska						

TRICARE Europe

Location	Name	Address	City	State	ZIP	Telephone
Europe, Africa, Middle East	WPS	PO BOX 8976	Madison	WI	53708-8976	(608) 224-2727

TRICARE Pacific

Location	Name	Address	City	State	ZIP	Telephone
Western Pacific (Japan, Guam, Korea, Thailand, etc.)	WPS	PO BOX 7985	Madison	WI	53707-7985	(608) 301-2310

TRICARE Latin America, Canada, Puerto Rico & Virgin Islands

Location	Name	Address	City	State	ZIP	Telephone
All of Latin America, Canada, Bermuda, Virgin Islands	WPS	PO BOX 7985	Madison	WI	53707-7985	(608)301-2311
Puerto Rico	WPS	PO BOX 7985	Madison	WI	53707-7985	(800) 700-7104

TRICARE For Life

Department	Address	Phone	Web Site
Claims Submission	WPS TRICARE For Life PO Box 7890 Madison, WI 53707-7890	(866) 773-0404 TDD (866) 773-0405	www.tricare4u.com
Appeals	WPS TRICARE For Life Attn: Appeals PO Box 7490 Madison, WI 53707-7490	(866) 773-0404 TDD (866) 773-0405	www.tricare4u.com

Pharmacy

Department	Address	Phone	Web Site
TMOP	Express Scripts P.O. Box 66518, St. Louis, MO 63166-6518	(866) 363-8667	www.express-scripts.com
Retail	Express Scripts P.O. Box 66518, St. Louis, MO 63166-6518	(866) 363-8779	www.express-scripts.com



Module Objectives



- Explain who may file claims and to whom they should be submitted
- Explain the process involved in beginning to resolve a claim issue
- Explain three reasons why a claim may be denied
- Recognize what can and cannot be appealed